



SOUTH DAKOTA BOARD OF NURSING  
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115  
(605) 362-2760 ♦ Fax: 362-2768 ♦ [www.nursing.sd.gov](http://www.nursing.sd.gov)

### Reactivation of Inactive Nursing License

Please follow instructions carefully to avoid delays in processing your reactivation. If any information is incorrect, incomplete or illegible, processing may be delayed. Upon receipt of all forms and fees your application will be considered for reactivation. You will be notified in writing if additional information is required.

To reactivate your inactive South Dakota nursing license, ***submit the following*** to the South Dakota Board of Nursing office at the address listed above:

- Completed Application to Reactivate an Inactive Nursing License indicating license to be reactivated.
- Completed Employment Verification Form
- Inactive Status Card, if still in your possession.
- Fee: **\$90**
  - Fee payment should be in the form of a money order or a personal check payable to South Dakota Board of Nursing. Fees are non-refundable and must accompany form. A \$20 fee will be charged for any insufficient check written.

Once you have met licensure reactivation requirements, you will be sent a certificate that will be valid from the date of issuance to your second birthday thereafter.



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### Application to *Reactivate* an Inactive Nursing License

I request to REACTIVATE each license checked: ☐ SD RN: License #(s): \_\_\_\_\_  
☐ SD LPN: License #(s): \_\_\_\_\_

*(Please Print)*

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_

Street/PO Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Telephone: Home: (\_\_\_\_) \_\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_\_

#### Declaration of Primary State of Residence

I declare that my primary state of residence (where I hold a driver's license, pay taxes, and/or vote) is:

\_\_\_\_\_. This is my "home state" under the Nurse Licensure Compact and is my "declared fixed permanent and principal home for legal purposes."

– OR –

☐ I am employed by the federal government, and so am not affected by the Nurse Licensure Compact requirements regarding Primary State of Residence. Name of employer: \_\_\_\_\_

#### Disciplinary Information

1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? <b>If Yes, provide a signed and dated explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2.	Is there any pending criminal prosecution against you which would constitute a felony?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4.	Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7.	Have you ever been treated for abuse or misuse of any alcohol or chemical substance?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8.	Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9.	Do you currently owe child support arrearages in the sum of \$1,000 or more?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**For 2-9 above, provide an explanation for each Yes response on a separate piece of paper, with a complete description of dates and circumstances. You must also send ALL supporting applicable documents.**

**Employment Information:** Select **ONE** response in each category below that best represents your current practice.

<b>Employment Status:</b> <input type="checkbox"/> Full-time Nurse <input type="checkbox"/> Part-time Nurse <input type="checkbox"/> Full-time other than Nursing <input type="checkbox"/> Part-time other than Nursing <input type="checkbox"/> Volunteer Nurse <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	<b>Where Presently Employed:</b> County: State: City: Zip Code:	<b>Type of Position:</b> <input type="checkbox"/> Nurse Management <input type="checkbox"/> Consultant <input type="checkbox"/> Case Manager <input type="checkbox"/> Nursing Program Faculty <input type="checkbox"/> Clinic Nurse <input type="checkbox"/> Staff Nurse <input type="checkbox"/> Charge Nurse <input type="checkbox"/> Inservice Educator/Staff Development <input type="checkbox"/> Advanced Practice Nurse <input type="checkbox"/> CNM <input type="checkbox"/> CNP <input type="checkbox"/> CRNA <input type="checkbox"/> CNS <input type="checkbox"/> Other
<b>Principle Field/Place of Employment:</b> <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home/Long Term Care <input type="checkbox"/> Nursing Education Program <input type="checkbox"/> Home Health / Hospice <input type="checkbox"/> School <input type="checkbox"/> Outpatient Surgical Center <input type="checkbox"/> Office / Clinic <input type="checkbox"/> Community Health <input type="checkbox"/> Self-Employed <input type="checkbox"/> Other	<b>Highest Degree Held:</b> <input type="checkbox"/> Diploma / Registered Nurse <input type="checkbox"/> Associate Degree/RN <input type="checkbox"/> Baccalaureate Degree/RN <input type="checkbox"/> Baccalaureate in other field <input type="checkbox"/> Masters in Nursing <input type="checkbox"/> Masters in other field <input type="checkbox"/> Doctorate (PhD, Ed, DNP) <input type="checkbox"/> Practical Nurse Diploma/A.D.  <b>Formal Education Activities:</b> <input type="checkbox"/> I am NOT taking courses toward an advanced degree in nursing <input type="checkbox"/> I am currently taking courses toward an advanced degree in nursing	

**What percent of your current position involves direct patient care?**

☐ 0%                     
 ☐ 25%                     
 ☐ 50%                     
 ☐ 75%                     
 ☐ 100%

**Do you intend to leave/retire from nursing practice in the next 5 years?**    ☐ YES    ☐ NO

**States other than South Dakota in which you are licensed as a nurse:**

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### Affidavit

I, the undersigned, declare and affirm under the penalties of perjury that this application for licensure in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

**Signature of Applicant** \_\_\_\_\_ **Date** \_\_\_\_\_

(7/08)



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### Verification of Employment

Applicant: Complete the top section of this form then forward to your employer or former employer. This form may be duplicated for additional employment verifications. Return completed form(s) to the South Dakota Board of Nursing.

To obtain/retain active licensure, a nurse must provide verification of a minimum of 140 hours in a 12-month period OR 480 hours in six years of employment/volunteer work in nursing.

**Please Print**

Name, First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

☐ I have been employed / volunteered as a nurse (LPN, RN).

☐ I have not been employed as a nurse within the last six years.

I hereby request and authorize my employer/former employer to release the information requested on this form to the South Dakota Board of Nursing for Licensure purposes.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

### This Section to be Completed by Employer (Provide Employment Hours Within the Last 6 Years) Note: This section Cannot be Signed by the Applicant

The above-named individual (was) employed/volunteered as a nurse

**From** \_\_\_\_\_  
Month/Date/Year

**To** \_\_\_\_\_  
Month/Date/Year

**Total hours worked in this period:** \_\_\_\_\_

I the undersigned declare and affirm that, according to our records and to the best of my knowledge and belief, the information provided above for purpose of licensure is true and correct.

\_\_\_\_\_  
Signature of Agency Representative/Title  
Who can verify/confirm number of hours employed/volunteered

\_\_\_\_\_  
Date

Name of Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_